Division of Health Care Finance and Policy
Claims Update – September 18, 2008

Topic: 835 Specification Updates

Update: On September 16, 2008, the Division posted updated 835 specifications on its webpage as well as posting of the LX Mapping explanations and the HSN Claims Adjustment Reason Code Listing. These updates are located in the same section as the previously posted specifications. Providers should contact the Division's Claims Customer Support Center at (866) 697-6080 with any questions.

Topic: REVS Display of HSN Eligibility for Commonwealth Care Eligible but Unenrolled Individuals

Update: On August 7, 2008, the Division of Health Care Finance and Policy distributed a letter describing an issue where certain individuals eligible for, but unenrolled in Commonwealth Care (CommCare) appeared in REVS as having Health Safety Net (HSN) eligibility when they were not actually eligible for HSN. Patients determined eligible for Commonwealth Care are eligible for the Health Safety Net for up to 90 days after their date of application if they remain unenrolled in an MCO plan, and between the day that they enroll in a plan and the day that the plan takes effect.

In order to ensure the proper coverage type is returned, REVS will be modified on 9/22/08 to address this issue. REVS will continue to show a coverage type of CommCare/HSN during the 90 day period after a member becomes CommCare eligible and is not enrolled in a MCO. After this date, REVS will then return a coverage type CommCare/Unenrl if the member remains unenrolled. When a member enrolls in a CommCare MCO after the 90 day period, the member's coverage type will appear as CommCare/HSN for 43 days prior to the day that his or her MCO coverage starts. As a result, the member's coverage type will appear as CommCare/Unenrl between the end of the 90 day period after the date of application and the beginning of the 43 day period prior to MCO coverage.

The Division apologizes for any inconvenience caused. If you have any questions regarding this notice, please contact the Division's Help Desk at (800) 609-7232 or at dhcfphelpdesk@state.ma.us.

Topic: Provider requests for HSN to review denied claims

Update: It is the provider's responsibility to conduct the first level review on all denied claims. Claims should only be submitted to the Division after the provider has thoroughly reviewed them and is unable to determine the cause for denial. To expedite the claim denial review process, the Division has identified the procedures below.

Requests submitted that do not comply with the procedures and format as stated will result in processing delays. We appreciate the cooperation of providers in partnering with the Division to ensure accurate and timely responses to claims reviews.

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Providers with questions regarding this notification should contact the Division's Help Desk at (800) 609-7232.

General Format & Process:

1. Providers must clearly identify a primary point of contact for responses and questions. Required contact information includes a phone number and email address.

2. An Excel spreadsheet must be submitted to dhcfphelpdesk@state.ma.us that contains the following information and in the following order. Providers must ensure that the spreadsheet is formatted to allow leading zeros. To ensure the security of confidential patient information, claims must be submitted in a password protected file with the password being submitted in a separate email.

- Claim Type – UB, 837I or ERBD
- TCN number exactly as submitted in the claim (including leading zeros, spaces, etc)
- Org ID
- Site Org ID (if applicable)
- RID number exactly as submitted in the claim
- UB RID process verification
- SSN exactly as submitted in the claim
- ERBD write off date (if applicable)
- Date of Service
- Claim submission Date
- Date of Claim Denial or Primary Payer Denial
- REVS print out attached

3. Claim denials must be sorted together by category to allow for greater efficiencies in claims review and provider response. Denials must be sorted within separate Excel worksheets (tabs) by ERBD, billing deadlines & eligibility.

4. The Division will review a random sample of 10 claims within each denial file. Findings that indicate that the randomly selected denials are accurate and that a provider did not exercise due diligence in reviewing these denials will result in the Division contacting the provider to discuss the findings and/or requesting that the provider review the file again before resubmitting to the Division.

Eligibility Denials:

1. Eligibility denials must be further broken out by SSN and non-SSN (RID) categories. Within the RID categories, providers must confirm (via the UB RID process verification in the spreadsheet) that denied claims have been submitted via the UB RID submission process and were again denied. Non-SSN claim denials that do not contain the RID confirmation will be sent back

to the Provider for additional information to enable accurate processing of the claim review.

2. Eligibility denials also require that a provider submit a recent REVS print out (no more than 1 week old from the date of sending the information to the Division) to verify that due diligence occurred in assessing whether an individual's eligibility had changed. Denials submitted for review without current REVS print outs will be sent back to the Provider for additional information to enable accurate processing of the claim review.

    - REVS print outs can be faxed (only in cases where total claims to be reviewed does not exceed 20) to the Division at (617) 727-7662 or mailed to 2 Boylston Street, Boston, MA 02116. Faxed or mailed packages should be sent to the attention of DHCFP Help Desk. Please make certain that a copy of the Excel spreadsheet is submitted with the REVS print outs and that each REVS print out contains its pertinent TCN.

Billing Deadline Denials:

1. Providers should refer to the Date of Service and Claim Submission Date fields in reviewing their claim denials for exceeding billing deadlines. Claims submitted after 120 days from the date of service (for original claims) and 90 days from the date of HSN claim or other Primary Payer denial will be denied. Claim denials in excess of the 120 & 90 day periods as noted previously should not be submitted to the Division for review.

Non-Covered Services:

1. The Noncovered / Covered Services listing is still being reviewed for correction. Providers will be notified once the listing has been fully determined. Covered service denials should only be submitted if a denial was received for a service that is not on the Division's non-covered service list.